FOR OFFICE USE ONLY
PREMIUM:
RATED BY:
EFFECTIVE DATE:
RETRO DATE:
REFUND AMOUNT DUE:

Allied World Insurance Company ("Insurer")

Return and make checks payable to:
American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

APPLICATION FOR MENTAL HEALTH COUNSELORS'AND MARRIAGE AND FAMILY THERAPISTS' PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

Notice to Florida Applicants:
License # A127510 issued to Richard C. Imbert

Notice to Iowa Applicants:
License # IA000000010776 issued to Richard C. Imbert

Notice to California Applicants:
License #0555091 issued to American Professional Agency, Inc.

NOTICE: THE COVERAGE OF A CLAIMS-MADE POLICY IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED, OR PROCEEDINGS FIRST BROUGHT, DURING THE POLICY PERIOD, AND REPORTED IN WRITING TO THE INSURER IN ACCORDANCE WITH THE TERMS OF THE POLICY. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR LEGAL OR INSURANCE ADVISOR.

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE SECTION V. (C), "MAXIMUM LIMIT OF LIABILITY - SEXUAL MISCONDUCT" IN THE POLICY).

- This Application must be completed in full, including all required attachments. Write "None" if that applies.
- Attach a separate sheet of paper if more space is needed to answer any question.
- We treat all Applications as confidential. If additional assurances of confidentiality are required, we are willing to address the Applicant's needs.

PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION

1. (a) Name of Applicant: Your Name License No.: N/A
Date of Birth: Your DOB E-mail address: Your Email

Office Telephone: ( ) Your Phone # Home Telephone: ( ) _____

Fax Number :( ) _____

(b) Coverage desired (check one): Choose which option applies to you, we recommend:

☒ Individual ☐ Partnership ☐ Professional Corporation (Incorporated as a P.C. or P.A.) ☐ LLC/LLP
☐ General Business Corporation: ☐ Profit ☐ Nonprofit ☐ Other (Please explain)

(If you are unsure of your corporate status, please check your Articles of Incorporation or other business documents.)

If you have checked anything other than "Individual" above, the following MUST BE INCLUDED: (1) a copy of articles of incorporation; (2) a letter describing all services provided; (3) any brochures if available; and (4) a listing of owners and/or partners, indicating the percentage of the business owned by each.

II. APPLICANT INFORMATION

2. Mailing Address: Your Address _____

_____

(City) (County) (State) (Zip code)

The amount we require for the Community Service Program:

3. (a) Policy Limits Requested (check one option):

☐ $200,000/600,000 ☐ $500,000/1,000,000 ☐ $1,000,000/1,000,000 ☒ $1,000,000/3,000,000
☐ $1,000,000/4,000,000 ☐ $1,000,000/5,000,000 ☐ $2,000,000/2,000,000 ☐ $2,000,000/4,000,000

The first Limit of Liability is applicable to each claim. All claims arising from a wrongful act, or a series of continuous, repeated or related wrongful acts, are treated as one claim. The second limit is the annual aggregate for all claims, which is the most the Insurer is liable for.

(b) Are you interested in obtaining limits higher than $5,000 for defense expenses related to licensing board investigations and other proceedings as described in the Policy? ☐ Yes ☒ No

If yes, choose the higher limit of liability desired for defense expenses related to licensing board investigations and other proceedings as described in the Policy:

☐ $25,000 ☐ $50,000 ☐ $75,000
☐ $100,000 ☐ $125,000 ☐ $150,000

(c) Have you ever had a request to increase your limits of liability for defense expenses for proceedings declined?
☐ Yes ☐ No If yes, please explain: _____

III. PRACTICE CHARACTERISTICS

4.

(a) **Please check the correct box for your rating group. If you are applying for corporate or partnership coverage, please check the boxes that pertain to all professionals.**

☐ Group 1- School Counselor
☐ Group 2 – Employed Counselor/Employed Marriage and Family Therapist
☐ Group 3 – B.A. Level-Employed Counselor
☐ Group 4 – Clergy & Pastoral Counselor
☐ Group 5 – Self-Employed Counselor
☒ Group 5 – Certified Hypnotist
☐ Group 5 – Sex Counselor
☐ Group 7 – Psychoanalysts
☐ Group 8 – Addiction Counselors
☐ Group 0 – Self Employed Marriage and Family Therapist

☐ **I understand that if I qualify under Groups 1-3, the policy will exclude coverage for private practice.**

(b) List your name and qualifications. In addition, list the names and qualifications of all your salaried (W2) employees, except clerical. If you are applying for a partnership policy, please list all partners as well. Please use a separate sheet of paper if additional space is required. Please include the premium charge indicated on the rate schedule for yourself and each employee and/or partner.

Name	All Degrees You Hold	Date Degree Received	Field of Study	I practice as a	*Number of hours practice each week	License or Certification			
						First Year Licensed/Cert	State	Title	License Number
Your Name	Diploma		Hypnosis/Hypnotist		20	N/A - - -	- - - - -	- - - - - - -	- - - - - - -

*You must include all hours you practice (privately and as an employee). If your total number of hours exceed 20, you do not qualify for the part-time rate.

5. If your highest degree is a BA, or if you are a new graduate or first-time practitioner, the following information must be included with your application and payment for review of acceptability.
   (a) The name of your supervisor: N/A
   (b) Supervisor's degree, field of study, license and/or certification: _____
   (Supervision must be provided by a professional with a minimum of a Master's Degree in the mental health field.)

6. Please list the number of your entire employed staff (except clerical) including yourself. N/A
   Note: Your staff is defined as your direct employees (for whom you file a W-2 form) and their names and credentials must be included with yours under Question 4. to correspond with the number listed here.

7. Is the applicant a member in good standing of any professional association? ☒ Yes ☐ No
   (a) If so, state the organization and type of membership.
   (i.e. Regular, Clinical, Associate, Student, etc.): _____

8. Are you engaged in self-employment, paid consultation (1099 form), private practice or volunteer work?
   ☒ Yes ☐ No

9. Are you employed (a W-2 form employee)? ☐ Yes ☒ No
   If yes, on a full-time or part-time (20 hours or less) basis? ☐ Full-Time ☐ Part-Time
   If yes, please complete the information below.

   (a) Name of your employer: _____
   (b) Address of your employer: _____

   If you are <u>both</u> self-employed and a W-2 employee, and wish to apply for part-time self-employed coverage, a separate statement indicating that you are fully insured by your employer at your W-2 employment must be submitted.

   ☐ ***I understand that if I apply and qualify for the exclusively employed rate, the policy will exclude coverage for private practice, self-employment, consulting, volunteering or social work outside of the course and scope of my employment.***

10. Do you or any person named in Question 4. own, partly own, manage or exercise any form of fiduciary control over any business enterprise that provides mental health services? ☐ Yes ☒ No
    If yes, please explain, and include the name of the business or enterprise: _____

11. (a) Does the Applicant use any Independent Contractors or Consultants (1099 form) whose services are in the mental health field and who you do billing for, share fees with or in any way derive income from the relationship? ☐ Yes ☐ No

(b) If yes, please list the name and professional credentials of each one.

All Independent Contractors or Consultants (1099 form) must be listed and premium shown on the rate schedule included. **You will be covered for their acts subject to the terms of the policy, but the independent contractors or consultants listed will not be insureds under the policy.**

Name of Independent Contractor or Consultant	Degree	Field of Study	License or Certification State	Title

If additional space is required, please use a separate sheet of paper to submit a complete listing.

12. Has any person or entity, based on a contractual obligation, requested that they be added to your policy as an Additional Insured? ☒ Yes ☐ No

(a) Name of proposed Additional Insured: Hypnosis Motivation Institute (HMI)

(b) Address of proposed Additional Insured: 18607 Ventura Blvd. Suite 310, Tarzana, CA 91356

(c) The Additional Insured is my:
☐ Employer ☐ Landlord ☐ Professional Corporation ☒ Other (Specify): School

(d) The Additional Insured gives me the following form to file with the IRS:
☐ W-2 form ☐ 1099 form ☐ Other (Specify): N/A

(e) Describe the relationship between you and the Proposed Additional Insured: School/ Internship Program

(f) Are you requesting that the person or entity named in 12(a) above be added as an Additional Insured in order to fulfill a contractual obligation? ☒ Yes ☐ No

If yes, provide full particulars: Pro Bono/Community Service Agreement

IV. PRIOR COVERAGE HISTORY

13. Please provide the following information for each person listed in Question 4. that has had prior Professional Liability Insurance, using a separate piece of paper if necessary.
If there is no insurance currently in force for any person listed in Question 4, please check here. ☐

	Effective Date – Termination Date	Carrier Name	Limits	Retention	Premium	Retro Date (Prior Acts Date)
Current Carrier			$	$	$	
Prior Carrier			$	$	$	
Prior Carrier			$	$	$	

ANSWER THESE IF THEY APPLY TO YOU

(a) Number of years continuously insured with present and prior carriers: _____

(b) Type of policy: ☐Occurrence ☐Claims-Made

(c) If prior professional liability insurance was on a Claims-Made basis, please check the appropriate box below:

(i) The Extended Reporting Period Endorsement has been purchased on my prior policy. ☐Yes ☐No

(ii) Prior Acts Coverage is requested on my new Claims-Made policy. ☐Yes ☐No

If yes, please indicate Retroactive Date desired: ___ / ___ / ____

Please attach a copy of the most recent policy Declarations Page for each person listed in Question 4, if you are requesting prior acts coverage.

(d) If you answered "No" to both Questions 13.(c)(i) and 13.(c)(ii), please review the statement and check the box below:

☐ I understand that I elected not to purchase the Extended Reporting Period Endorsement on my prior Claims-Made policy, and I also have elected not to purchase the Prior Acts Coverage on my new Claims-Made policy. I understand that I will be uninsured for the period in which my prior Claims-Made policy existed. Furthermore, I understand that because of this there will be a gap in my insurance coverage.

V. REPRESENTATIONS

PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE*

14. After inquiry* of each individual listed in Question 4:

* "After inquiry" means that the Applicant has inquired of each person as to whether he/she has information pertinent to this question.

If you answer "Yes" to any question below, please include all documents pertinent to the situation you are describing.

(a) Has any person named in Question 4, including yourself, ever been convicted of a crime in any state or country? ☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered. _____

_____

_____

(b) Has any person named in Question 4, including yourself, ever had any licensing board or professional ethics body require the surrender of a license or found any such person or you guilty of a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐Yes ☐No

If yes, please give full particulars and provide copies of charges, correspondence and any findings in order for your Application to be considered.

_____

_____

(c) Are there any complaints, charges or investigations pending against any person named in Question 4, including yourself, by a licensing board or professional ethics body for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐Yes ☐No

If yes, please give full particulars and copies of charges, correspondence and any findings in order for your Application to be considered._____

_____

_____

NOTE: MISSOURI APPLICANTS DO NOT RESPOND TO QUESTION 14.(d)

(d) Has any person named in Question 4, including yourself, ever had any insurance company or Lloyd's decline, cancel, refuse to renew, or accept only on special terms any professional liability insurance? ☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered._____

_____

_____

(e) Has any professional liability claim or suit ever been made against any person named in Question 4, including yourself, their predecessors in business or against any past or present partner(s)? ☐Yes ☐No

If yes, please give full particulars and copies of any summons and complaints, pertinent correspondence and outcome, if any, in order for your Application to be considered.

_____

_____

(f) Are there any circumstances, including any loss of private or confidential information, of which any person named in Question 4, including yourself, is aware of that may result in any professional liability claim or suit being made against any person named in Question 4, including yourself, their predecessors in business or against any past or present partner(s)? ☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered._____

_____

_____

(g) Is any person named in Question 4, including yourself, engaged in or ever been engaged in any sexual misconduct* with any of your current or former patients or any current or former patient's spouse or any person with a direct relationship to the current or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)? ☐Yes ☐No

(*"Sexual misconduct" means any actual or alleged erotic physical contact or attempt, threat or proposal thereof.)

If yes, please give full particulars in order for your Application to be considered.

_____

_____

(h) Are you now being or have you ever been, treated for a serious health problem that did or can impair your ability to treat clients? ☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered.

_____

_____

VI. NOTICES TO APPLICANT & FRAUD WARNINGS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO ALABAMA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF."

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

NOTICE TO HAWAII APPLICANTS: "FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH."

NOTICE TO KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME."

NOTICE TO LOUISIANA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

NOTICE TO MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO NEW YORK APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1)."

NOTICE TO OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW."

NOTICE TO PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO RHODE ISLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

NOTICE TO TEXAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

NOTICE TO VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

NOTICE TO VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

NOTICE TO WASHINGTON APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

NOTICE TO WEST VIRGINIA: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO ALL OTHER APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

VII. DECLARATION AND SIGNATURE

I understand that it is my obligation to maintain any license required in the jurisdictions in which I practice.

Date: Today's Date
(This application must be dated within 30 days of receipt)

Signature: Your Signature
(APPLICANT / OWNER / PRESIDENT OF CORPORATION)

Title: Certified Master Hypnotist

Application must be signed, dated, fully completed and accompanied by the premium to be considered.

*This is your current active title!

Please make checks payable and mail to: American Professional Agency, Inc.

Producer Signature:

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694
www.americanprofessional.com

Email Form **Print Form**

Save form first on your computer before emailing.

THINGS TO KEEP IN MIND:

1) The email to send your copy to is mentalhealth@americanprofessional.com

2) Prior to sending your application, make sure you are already an AHA member! That way you have your membership and certification done

Allied World Insurance Company ("Insurer")

Return to:
American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
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HYPNOTIST/HYPNOTHERAPIST QUESTIONNAIRE

FOR MENTAL HEALTH COUNSELORS' PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE

If you are applying for coverage as a Hypnotherapist, the following questions MUST be answered to determine if you are eligible for coverage.

APPLICANT NAME: Your Name

ADDRESS: Your Address

CITY STATE ZIP

1. Do you hypnotize anyone for entertainment purposes? ☐ Yes ☒ No
2. Do you perform hypnosis as a form of anesthesia? ☒ Yes ☐ No (By Medical referral only)
3. Do you provide any hands on therapy? ☐ Yes ☒ No
4. Do you provide life regression therapy? ☒ Yes ☐ No (By client request only)

If you answered "YES" to any of these questions, please submit in writing a detailed explanation of the services being offered.

NOTICE & SIGNATURE:

Applicant understands the information submitted herein becomes part of the Applicant's Application for Mental Health Counselors' Professional and Business Liability Insurance Coverage, and is subject to the same representations and conditions.

Your Signature
Signature

Today's Date
Date

Your Name
Print Name